A *weighty* issue for general practitioners

Almario v Varipatis (No. 2) [2012] NSWSC 1578

By Sally Gleeson

By its very nature, medical negligence litigation is complex. The NSW Supreme Court case of *Almario v Varipatis* is a case in point. How one general practitioner (GP) treated a patient's serious liver problem caused by obesity opened up a forum for explicit value judgements about the issue of weight and, more generally, about obesity within society. The case highlighted the role that perspective, appraisal and ultimately opinion can play within the judicial process.

THE FACTS

The plaintiff, Luis Almario, was 53 years old when he first consulted the defendant, Dr Emmanuel Varipatis, in August 1997. At the time, Mr Almario weighed 140 kilograms. By the time he was diagnosed with micronodular cirrhosis of the liver and liver failure on 23 June 2003, no treatment could alleviate this irreversible condition. Mr Almario's condition deteriorated into terminal liver cancer, in the form of hepatocellular carcinoma, caused by the cirrhosis. There was no dispute at trial that the progression of the plaintiff's liver disease had its origins in non-alcoholic fatty liver disease (NAFLD), which was more likely to develop in people who were morbidly obese and consequently diabetic and hypertensive. Mr Almario's condition is fatal.

Whether the defendant was negligent could be addressed only by carefully examining whether there was a positive obligation to act in the particular circumstances. In essence, the trial judge answered this question in the affirmative. The defendant appealed the judgment and the NSW Supreme Court of Appeal allowed the appeal and set aside the judgment and orders made by the trial judge. The message for GPs appeared to be loud and clear: when faced with similar cases, nothing more was required to be done. Did the case turn on its own facts or did Mr Almario merely fail to meet the applicable legal tests?

THE DUTY OF CARE AND ITS SCOPE

The plaintiff consulted the defendant over a period of 14 years. The defendant referred the plaintiff to specialists, ordered investigations, provided advice and treatment on a range of conditions, including what the defendant said were conditions secondary to toxic workplace exposure. Dr Varipatis had a special interest in environmental and nutritional medicine. In fact, the plaintiff had sought him out for this very reason. The plaintiff mistakenly believed that all of his health problems were due to workplace exposure to toxic chemicals during his employment as a cleaner at the Union Carbide site at Rhodes. He subsequently brought and lost an action against his employer for this toxic exposure, an action supported by the defendant with his various expert reports.

Alongside his special interest in environmental medicine, however, the defendant was the plaintiff's GP and therefore primary care provider in the relevant period. As the plaintiff's GP, the standard of care expected of him was 'that of the ordinary skilled person exercising and professing to have that special skill'.[1] Thus, the standard to be expected of the defendant was that of an ordinary skilled GP. Medical practitioners have a duty to exercise reasonable care and skill in the provision of their professional advice and treatment.[2] That duty covers all aspects of the doctor-patient relationship, including the examination of the patient, and the provision of information, diagnosis and treatment.[3] This was found to apply to Dr Varipatis, despite his special interest.

A contentious issue in the case was whether, in light of the defendant's special interest and the plaintiff's mistaken belief as to the cause of his problems, there should have been an obligation on the defendant to disabuse his patient of his incorrect belief about the source of his physical ailments. It was argued on behalf of the plaintiff that his beliefs about the cause of his problems became entrenched and that without proper education, he effectively resigned himself to the notion that he suffered a complex nightmare of symptoms, driven by toxic exposure, none of which he had any ability to reverse or alter. Even the trial judge dabbled with this additional liability point, despite the strength of the expert evidence on the lack of a medical nexus between toxic chemical exposure and liver disease. Whether this further liability point advanced the plaintiff's case was, in the end, unclear. What was clear, however, was that the defendant's obligation could not be limited by his special interest in environmental or nutritional medicine. The defendant's conduct needed to be judged by reference not to what was customary or usual practice of GPs with such a special interest, but by reference to the functions of the *normal* GP.

Another argument in support of the defendant's primary relationship with the plaintiff was that of the longevity

of the duty owed by a GP; in other words, whether a GP is responsible for a persistent health problem. It was argued that the defendant owed the plaintiff a continuing or ongoing duty. The relationship between doctor and patient, once established, cannot be ended unilaterally by the doctor. It lasts until treatment is no longer required, or until the relationship is dissolved by consent or reasonable notice is given by a doctor to a patient to give the patient the opportunity to engage the services of another doctor.[4] The scope of a medical practitioner's continuing duty in relation to a persistent health problem was described by Powell JA:

> 'It seems to me that, in a case such as this was, in which a patient consults a doctor concerning what appears to be a persisting health problem, the doctor is, as a consequence of his being consulted, and with a view to restoring the patient's health, called upon to examine the patient; to carry out, or have carried out, such tests or procedures as might be thought necessary, or desirable, to be carried out to enable or to assist in, diagnosis; to diagnose the cause of the patient's problem; to determine what treatment is called for; to prescribe that treatment; or to set in train steps for that treatment to be given; and to advise the patient in relation to the condition diagnosed and the treatment prescribed or proposed.
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> If this be the scope of the doctor's duty to his patient in such a case, then, as it seems to me, if the doctor, without reasonable cause, fails to carry out, or to have carried out, such of the steps to which I have referred as, in the circumstances, where necessary or desirable, or although carrying them out, does so without due care and skill, he has failed in the performance of his duty to the patient.'[5]

In summary, the scope of the defendant's duty to the plaintiff in this case was to exercise the standard of care expected of an ordinary skilled GP. It was to provide those services to be expected of an ordinary skilled practitioner. The defendant had a continuing obligation because the plaintiff had a persistent health problem and regarded the defendant as his GP. The defendant's duty extended to taking appropriate history, carrying out examinations, tests or procedures to enable or to assist in the diagnosis of the cause of the plaintiff's persistent health problems. It was argued that he had an obligation to set in train steps to treat and manage his patient's conditions and to advise him in relation to differential diagnoses and the treatment and management plans proposed for any such diagnosis. In the particular circumstances of the case, the defendant needed to act in this manner until a solution to the health problem was reached, that health problem being a deteriorating liver.

The defendant gave evidence during the trial that he had advised the plaintiff to lose weight throughout their consulting relationship. The question became whether, if accepted, that advice was sufficient, particularly in light of the gravity of the plaintiff's deteriorating liver condition, as within the defendant's knowledge. The Court of Appeal stated that a GP *may* be obliged, in taking reasonable care for the health of a patient, to advise that weight loss is necessary to protect his or her health; to discuss the means by which that may be achieved and to offer (and to encourage acceptance of) appropriate referrals. The Court found, however, that the expert evidence of the GPs in this case did not demonstrate any obligation, or even power, to do more than that.[6] Moreover, in circumstances where the plaintiff was found to have historically refused to take the firm advice of his GP, and of experts to whom he had been referred, the defendant did not breach any duty in not writing a further referral. The duty of care, the Court of Appeal found, stopped short of requiring an exercise in futility.[7]

This type of reasoning is powerful. While there is no doubt a certain degree of discretion over weight loss, obesity – and particularly morbid obesity – is a serious medical condition of complex aetiology. There was no discord among the experts called to give evidence at trial on the complexity and seriousness of this disease, often difficult to treat. What is essential, it was argued, is the provision of proper advice and information about obesity, the risks associated with it and the need for aggressive therapy. The particular patient's attitude and motivation are important factors, particularly in a case such as this where the plaintiff held ignorant views about the cause of his significant weight issue. It was argued that proper education could often stimulate motivation. Although seemingly simple, this argument requires a laborious mental shift from the conventional view that obesity represents an individual's misdemeanour.

The trial judge agreed with this reasoning and found that the defendant had breached his duty of care by:

(a) failing to refer the plaintiff to a bariatric surgeon for consideration of the suitability for surgery of that type by 30 July 1998;
(b) in the alternative to (a), failing to take the appropriate steps to re-refer the plaintiff to an obesity clinic; and
(c) failing to refer the plaintiff to a hepatologist, or similarly qualified physician, by the end of September 2000 for the specific investigation and treatment of his liver condition.

Furthermore, the trial judge found that the plaintiff succeeded on only one ground of causation, that being that only through bariatric surgery would he have avoided the progress of his condition to cirrhosis and its complications, because he would have been unable to lose sufficient weight by conservative means. In other words, the plaintiff ultimately required aggressive and surgical intervention. Thus there was an emphatic need to address this plaintiff's morbid obesity because for him, this would have been a life-saving measure. Surgery would have been followed by weight loss, which would have halted the progression of the plaintiff's underlying liver disease. The plaintiff would then have avoided the development of liver cancer or, at least, liver cancer at the time that he did. Additionally, his co-morbidities would have improved dramatically or may perhaps have been reversed.

Startlingly, the defendant admitted that he knew that the plaintiff had had liver function abnormalities that had been present for at least five years prior to his first consultation with him. He knew that the plaintiff suffered from morbid obesity, poorly controlled diabetes mellitus and early liver disease. >>

The defendant was concerned that the plaintiff had abnormal liver function tests that had been persistently abnormal. He also knew that the plaintiff was poorly compliant with prescriptive treatment he had received in respect of those matters, including the absolute necessity for him to lose weight by dieting. There were clear references in other treating practitioners' records about the plaintiff's weight problem, which impeded his improved wellbeing. It was recorded in previous treaters' records that the plaintiff had lost significant amounts of weight on occasions. This of course implied that the plaintiff, at least by those other treating practitioners, had been given advice to lose weight. The defendant argued that the plaintiff had independent medical conditions that required investigation, as they may have been impacting on his liver. It was reasonable, therefore, to delay specialised treatment for the liver. The defendant did in fact refer the plaintiff for specialist treatment in relation to those independent conditions, but not in relation to the liver. In any event, it was clear by implication that in early 1998 the defendant knew that the plaintiff had persistently abnormal liver function tests. Indeed, he advised the plaintiff's solicitors in the workplace action that he had persistent liver inflammation.

The trial judge accepted the defendant's argument on the reasonableness of delaying treatment and extended his leniency to 28 August 2000 when the plaintiff's liver results remained abnormal and all other possible medical conditions that could have caused this abnormality had been excluded. Despite this, no further liver function tests were ordered by the defendant. The trial judge noted that the defendant had agreed that the results, with which he was uncomfortable, showed *a man that could have very serious pathology affecting his liver*. Notwithstanding this, there was no referral of the plaintiff by the defendant to a hepatologist. The trial judge therefore found that from September 2000 onwards, a referral to a hepatologist was required as a matter of some urgency. It was not until 22 May 2003 that the defendant did so and, by then, it was discovered that the plaintiff had already developed cirrhosis.

CAUSATION

The case on causation was a greater exercise in extrapolation for the trial judge. The questions as to whether a different outcome would have been achieved had the defendant referred the plaintiff to a hepatologist, bariatric surgeon or to an obesity clinic were difficult to determine. The trial judge found that the plaintiff needed to succeed on causation by establishing that, on the balance of probabilities, positive intervention by the defendant would have arrested, indeed reversed, the ordinary course of his disease. Even if the plaintiff had undergone bariatric surgery, he would have needed to make a colossal lifestyle change to achieve and then maintain the weight loss. The defendant argued that this would have been an impossible feat for the plaintiff to achieve, based on his previous track record of failing to adopt proper eating habits. The *Civil Liability Act* 2002 (NSW) sets a two-pronged causation test at s5D(1). The first limb entails the question as to whether the defendant's conduct was historically involved in the plaintiff's loss (the 'but for' test). The second limb asks whether the defendant ought to be held liable for the harm sustained.[8] The joint report of the expert surgeons in the case concluded that the plaintiff would have been considered for bariatric surgery, probably laparoscopic adjustable gastric banding. The trial judge took a leap on causation and formed the view that, on the balance of probabilities, the plaintiff would have in fact complied with the lifestyle changes necessary to succeed in overcoming his obesity following bariatric surgery.

The finding on causation based on what would have been achieved by referring the plaintiff to a hepatologist by the end of September 2000 was a more difficult one to justify for the trial judge. The hepatology experts called on behalf of the defendant were overwhelmingly of the view that referral for bariatric surgery in the relevant period was not the standard practice of a hepatologist. A greater chance of success for the plaintiff on causation would have been through direct referral to a bariatric surgeon, as the joint evidence by the expert surgeons was more convincing. These expert surgeons agreed that bariatric surgery was reserved for patients who had tried to lose weight by conservative (medical) means and had demonstrably failed. The trial judge believed that the plaintiff's history seemed to eminently qualify the plaintiff for consideration. The expert surgeons were also in agreement that had the plaintiff successfully undergone bariatric surgery before he developed cirrhosis, it was more likely than not that he would have avoided progression to cirrhosis, liver failure and liver cancer. All of the expert surgeons further agreed that the rate of success of adjustable gastric banding in terms of weight loss and adaptation to changes in lifestyle is greater than 50 per cent

CONCLUSION

The trial judge ordered the defendant to pay Mr Almario $364, 372.48 in damages. Despite this conservative award in favour of the plaintiff, the Court of Appeal disagreed wholeheartedly and overturned the award. One view is that Mr Almario's case highlights the disrepute often associated with obesity. Perhaps now this medical epidemic and its serious co-morbidities – including diabetes, musculoskeletal problems, obstructive sleep apnoea, respiratory impairment, hypertension and liver disease – will receive medical attention that is concerted, informed and multidisciplinary in nature, notwithstanding the outcome. While there is no doubt that particular beliefs and bias can tip the balance within the legal process, conversely, this type of litigation can trigger a shift in mentality on controversial health issues. ■

Notes: **1** *Rogers v Whitaker* (1992) 175 CLR 479 at [483], [487]. **2** *Ibid,* at [483]. **3** *Ibid.* **4** *Tai v Hatzistavou* [1999] NSWCA 306 at [76]. **5** *Ibid,* at [101]-[102]. **6** *Varipatis v Almario* [2013] NSWCA 76 at [20] – [30]. **7** *Ibid.* **8** *Ruddock v Taylor* [2003] NSWCA 262 at [87]; *Harvey v PD* [2004] NSWCA 97 at [186] – [187]; *Pledge v Roads and Traffic Authority* [2004] HCA 13 at [10] per Hayne J.

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